		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040295

Facility Name: RENAISSANCE CARE CENTER

Address: 1675 E. ASH STREET (Number) CANTON (City) 61520 (Zip Code)

County: FULTON

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 37-1304212

Date of Initial License for Current Owners: 2/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) VICE PRESIDENT

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRKUPNICK, BOKOR, KAGDA & BROOKS, LTD. 3750 W. DEVON AVE.,LINCOLNWOOD,IL 60712
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	152	Skilled (SNF)	152	55,480	1
2	42	Skilled Pediatric (SNF/PED)	42	15,330	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	194	TOTALS	194	70,810	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			956	956	8
9	SNF/PED	17,470			17,470	9
10	ICF	20,831	2,433	10	23,274	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,301	2,433	966	41,700	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.89%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 956

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	138,760	5,607	8,216	152,583		152,583		152,583			1
2	Food Purchase		285,542		285,542		285,542	(172)	285,370			2
3	Housekeeping	138,641	46,819		185,460		185,460	554	186,014			3
4	Laundry	54,290	21,085	1,872	77,247		77,247		77,247			4
5	Heat and Other Utilities			109,639	109,639		109,639	1,683	111,322			5
6	Maintenance	46,727	22,211	12,262	81,200		81,200	85	81,285			6
7	Other (specify):* SCAVENGER			4,328	4,328		4,328		4,328			7
8	**TOTAL General Services**	378,418	381,264	136,317	895,999		895,999	2,150	898,149			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,903,016	167,449	9,795	2,080,260		2,080,260	20,483	2,100,743			10
10a	Therapy	19,429	4,184	5,856	29,469		29,469		29,469			10a
11	Activities	35,878	1,361	238	37,477		37,477		37,477			11
12	Social Services	63,149		5,113	68,262		68,262		68,262			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,021,472	172,994	21,002	2,215,468		2,215,468	20,483	2,235,951			16
	C. General Administration											
17	Administrative	48,743		11,975	60,718		60,718	46,380	107,098			17
18	Directors Fees											18
19	Professional Services			70,222	70,222		70,222	(26,832)	43,390			19
20	Dues, Fees, Subscriptions & Promotions			37,319	37,319		37,319	(10,844)	26,475			20
21	Clerical & General Office Expenses	60,957	20,540	167,866	249,363		249,363	(68,510)	180,853			21
22	Employee Benefits & Payroll Taxes			375,431	375,431		375,431	27,780	403,211			22
23	Inservice Training & Education			1,947	1,947		1,947		1,947			23
24	Travel and Seminar			1,931	1,931		1,931	2,762	4,693			24
25	Other Admin. Staff Transportation			10,316	10,316		10,316	5,033	15,349			25
26	Insurance-Prop.Liab.Malpractice			92,030	92,030		92,030	2,046	94,076			26
27	Other (specify):*			5,376	5,376		5,376	(5,376)				27
28	**TOTAL General Administration**	109,700	20,540	774,413	904,653		904,653	(27,561)	877,092			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,509,590	574,798	931,732	4,016,120		4,016,120	(4,928)	4,011,192			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number RENAISSANCE CARE CENTER #0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			35,700	35,700		35,700	242,021	277,721			30
31	Amortization of Pre-Op. & Org.							4,260	4,260			31
32	Interest			9,099	9,099		9,099	590,141	599,240			32
33	Real Estate Taxes			41,821	41,821		41,821		41,821			33
34	Rent-Facility & Grounds			801,189	801,189		801,189	(794,609)	6,580			34
35	Rent-Equipment & Vehicles			7,236	7,236		7,236	325	7,561			35
36	Other (specify):* STORAGE			480	480		480		480			36
37	TOTAL Ownership			895,525	895,525		895,525	42,138	937,663			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,434	80,310	106,744		106,744		106,744			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			106,215	106,215		106,215		106,215			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		26,434	186,525	212,959		212,959		212,959			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,509,590	601,232	2,013,782	5,124,604		5,124,604	37,210	5,161,814			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,022)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(172)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,305)	21		18
19	Entertainment		20		19
20	Contributions	(2,431)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,376)	27		24
25	Fund Raising, Advertising and Promotional	(8,667)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(16,107)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,080)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	76,290		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 76,290		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 37,210		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

RENAISSANCE CARE CENTER

ID# 0040295

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING SALARY	(16,107)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(16,107)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(172)	0	0	0	0	0	0	0	0	0	0	(172)	2
3	Housekeeping	0	0	554	0	0	0	0	0	0	0	0	554	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,683	0	0	0	0	0	0	0	0	1,683	5
6	Maintenance	0	0	85	0	0	0	0	0	0	0	0	85	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(172)	0	2,322	0	0	0	0	0	0	0	0	2,150	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	20,483	0	0	0	0	0	0	0	0	20,483	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	20,483	0	0	0	0	0	0	0	0	20,483	16
	C. General Administration													
17	Administrative	0	(11,975)	58,355	0	0	0	0	0	0	0	0	46,380	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(32,410)	5,578	0	0	0	0	0	0	0	0	(26,832)	19
20	Fees, Subscriptions & Promotions	(11,098)	0	254	0	0	0	0	0	0	0	0	(10,844)	20
21	Clerical & General Office Expenses	(20,412)	(140,737)	92,639	0	0	0	0	0	0	0	0	(68,510)	21
22	Employee Benefits & Payroll Taxes	0	0	27,780	0	0	0	0	0	0	0	0	27,780	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,762	0	0	0	0	0	0	0	0	2,762	24
25	Other Admin. Staff Transportation	0	0	5,033	0	0	0	0	0	0	0	0	5,033	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,046	0	0	0	0	0	0	0	0	2,046	26
27	Other (specify):*	(5,376)	0	0	0	0	0	0	0	0	0	0	(5,376)	27
28	**TOTAL General Administration**	(36,886)	(185,122)	194,447	0	0	0	0	0	0	0	0	(27,561)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,058)	(185,122)	217,252	0	0	0	0	0	0	0	0	(4,928)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,022)	241,350	2,693	0	0	0	0	0	0	0	0	242,021	30
31	Amortization of Pre-Op. & Org.	0	4,260	0	0	0	0	0	0	0	0	0	4,260	31
32	Interest	0	590,140	1	0	0	0	0	0	0	0	0	590,141	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(801,189)	6,580	0	0	0	0	0	0	0	0	(794,609)	34
35	Rent-Equipment & Vehicles	0	0	325	0	0	0	0	0	0	0	0	325	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,022)	34,561	9,599	0	0	0	0	0	0	0	0	42,138	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(39,080)	(150,561)	226,851	0	0	0	0	0	0	0	0	37,210	45

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTI	SKOKIE	BOOKKEEPING/
				MANAGEMENT		MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 11,975	CERTIFIED HEALTH MANAGEMENT		$	$ (11,975)	1
2	V	21	BOOKKEEPING FEES	141,940				(141,940)	2
3	V	19	ADMIN CONSULTING FEES	32,410				(32,410)	3
4	V								4
5	V	34	RENT	801,189	RENAISSANCE CARE CENTER LLC			(801,189)	5
6	V	21	OFFICE EXPENSE		" " " "		1,203	1,203	6
7	V	30	DEPRECIATION		" " " "		241,350	241,350	7
8	V	31	AMORTIZATION		" " " "		4,260	4,260	8
9	V	32	INTEREST		" " " "		590,140	590,140	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 987,514			$ 836,953	$ * (150,561)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 554	$ 554	15
16	V	5	ELECTRIC & GAS				1,683	1,683	16
17	V	6	MAINTENANCE				85	85	17
18	V	10	NURSING/MEDICAL RECORDS				20,483	20,483	18
19	V	17	ADMIN SALARIES				58,355	58,355	19
20	V	19	PROFESSIONAL FEES				5,578	5,578	20
21	V	20	FEE, SUBSCRIPTIONS				254	254	21
22	V	21	OFFICE EXP.				92,639	92,639	22
23	V	22	EMPLOYEE BENEFITS				27,780	27,780	23
24	V	24	TRAVEL/SEMINAR				2,762	2,762	24
25	V	25	TRANSPORTATION				5,033	5,033	25
26	V	26	INSURANCE				2,046	2,046	26
27	V	30	DEPRECIATION				2,693	2,693	27
28	V	32	INTEREST				1	1	28
29	V	34	OFFICE RENT				6,580	6,580	29
30	V	35	EQUIPMENT RENTAL				325	325	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 226,851	$ * 226,851	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATIVE		NONE			SALARY	$ 10,270	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,270		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUTIE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	272,818	8	$ 3,625	$	41,700	$ 554	1
2	5	ELECTRIC & GAS	" " "	272,818	8	11,011		41,700	1,683	2
3	6	MAINTENANCE	" " "	272,818	8	557		41,700	85	3
4	10	NURSING/MEDICAL RECORD	" " "	272,818	8	134,010	134,010	41,700	20,483	4
5	17	ADMIN SALARIES	" " "	272,818	8	381,783	381,783	41,700	58,355	5
6	19	PROFESSIONAL FEES	" " "	272,818	8	36,495		41,700	5,578	6
7	20	FEE, SUBSCRIPTIONS	" " "	272,818	8	1,662		41,700	254	7
8	21	OFFICE EXP.	" " "	272,818	8	606,084	496,771	41,700	92,639	8
9	22	EMPLOYEE BENEFITS	" " "	272,818	8	181,747		41,700	27,780	9
10	24	TRAVEL/SEMINAR	" " "	272,818	8	18,072		41,700	2,762	10
11	25	TRANSPORTATION	" " "	272,818	8	32,928		41,700	5,033	11
12	26	INSURANCE	" " "	272,818	8	13,389		41,700	2,046	12
13	30	DEPRECIATION	" " "	272,818	8	17,618		41,700	2,693	13
14	32	INTEREST	" " "	272,818	8	9		41,700	1	14
15	34	OFFICE RENT	" " "	272,818	8	43,046		41,700	6,580	15
16	35	EQUIPMENT RENTAL	" " "	272,818	8	2,124		41,700	325	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,160	$ 1,012,564		$ 226,851	25

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RENAISSANCE CARE CENTER LLC
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	OFFICE EXPENSE	DIRECT COSTS	1	1	$ 1,203	$	1	$ 1,203	1
2	30	DEPRECIATION		1	1	241,350		1	241,350	2
3	31	AMORTIZATION		1	1	4,260		1	4,260	3
4	32	INTEREST		1	1	590,140		1	590,140	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 836,953	$		$ 836,953	25

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB BANK/BANKFINANCIAL		X	MORTGAGE	$39,927.00	4/00	$ 4,152,030	$ 3,953,139	3/20	9.7500	$ 393,763	1
2	GERSHON BASSMAN	X		MORTGAGE	$16,993.00	4/00	1,789,668	1,697,288	3/20	9.7500	167,065	2
3	BANK FINANCIAL		X	MORTGAGE	$14,812.00	4/00	715,867	454,294	9/03		29,312	3
4	URBANA CARE& REHAB	X		TEMP LOAN							607	4
5	AICC		X	INS FINANCING							1,520	5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL				180,131			6,549	6
7	OFFICERS	X		WORKING CAPITAL							423	7
8	RELATED PARTY	X									1	8
9	TOTAL Facility Related				$71,732.00		$ 6,657,565	$ 6,284,852			$ 599,240	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,657,565	$ 6,284,852			$ 599,240	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 40,241	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 40,625	2
3. Under or (over) accrual (line 2 minus line 1).		$ 384	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 41,437	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For _____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 41,821	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	37,551	8
	1998	35,422	9
	1999	38,438	10
	2000	39,452	11
	2001	40,625	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RENAISSANCE CARE CENTER COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0040295

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 X40 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-25-101-025	NURSING HOME	$ 40,624.68	$ 40,624.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,624.68	$ 40,624.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 291,000	1
2					2
3	TOTALS			$ 291,000	3

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	194		2000		$ 5,238,000	$ 190,136	27.5	$ 190,473	$ 337	$ 515,743	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1993	9,646	303	39	247	(56)	2,878	9
10	LEASEHOLD IMPROVEMENTS			1994	9,445	242	39	242	0	2,003	10
11	TILE,OVERBED FIXTURES, AC			1995	2,316	59	39	59	0	530	11
12	WATER/GAS LINE WORK			1995	6,797	174	39	174	0	1,567	12
13	ROOF REPAIR			1995	2,060	53	39	53	(0)	451	13
14	NURSE STATION			1997	5,222	134	39	134	(0)	813	14
15	ROOF REPAIR			1997	7,235	186	39	186	(0)	1,069	15
16	WATER STORAGE TANK			1997	6,550	168	39	168	(0)	976	16
17	CARPET, LIGHT FIXTURES			1997	4,570	117	39	117	0	664	17
18	DOORS			1998	3,264	84	39	84	(0)	391	18
19	ROOFING			1998	7,000	179	39	179	0	768	19
20	WALLPAPER, TILES, BUMPER GUARDS			1998	26,992	692	39	692	0	2,931	20
21	LANDSCAPING, SIDEWALK,FENCE			1998	10,578	271	39	271	0	1,138	21
22	FLOOR/CEILING TILE			1999	8,975	230	39	230	0	892	22
23	LANDSCAPING			1999	12,187	312	39	312	0	1,133	23
24	OUTDOOR SIGN			2000	1,023	37	27.5	37	0	100	24
25	ROOF REPAIR			2000	8,123	295	27.5	295	0	663	25
26	ROOFTOP CONDENSER UNITS			2001	4,850	176	27.5	176	0	252	26
27	LIFT			2001	1,396	51	27.5	51	(0)	57	27
28	ROOF IMPROVEMENTS			2001	42,200	1,535	27.5	1,535	(0)	1,855	28
29	SIDEWALK REPLACEMENT			2002	1,152	373	15	38	(335)	38	29
30	SHOWER ROOM IMPROVEMENTS			2002	1,100	18	27.5	20	2	20	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,420,681	$ 195,825		$ 195,775	$ (50)	$ 536,934	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 202,751	$ 16,378	$ 20,275	$ 3,897	10 YRS	$ 120,300	71
72	Current Year Purchases	24,918	10,964	4,984	(5,980)	5 YRS	4,984	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		53,907	53,907				74
75	TOTALS	$ 227,669	$ 81,249	$ 79,166	$ (2,083)		$ 125,284	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$ 5,840	$	$	$		$ 6,570	76
77				13,900	2,669	2,780	111	5	10,008	77
78										78
79										79
80	TOTALS			$ 19,740	$ 2,669	$ 2,780	$ 111		$ 16,578	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,959,090	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 279,743	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 277,721	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,022)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 678,796	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,236 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 27,131	$		$ 27,131	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,949			6,949	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			44,045			44,045	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				16,415		16,415	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-3				2,185			2,185	12
13	MEDICAL SUPPLIES Other (specify): LABORATORY	39-2 39-2					7,188 2,831		7,188 2,831	13
14	TOTAL			$		$ 80,310	$ 26,434		$ 106,744	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 22,000)	1,160,286		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,536		6
7	Other Prepaid Expenses	322		7
8	Accounts Receivable (owners or related parties)	17,882		8
9	Other(specify): REAL ESTATE ESCROW	15,247		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,227,273	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	182,680		15
16	Equipment, at Historical Cost	247,409		16
17	Accumulated Depreciation (book methods)	(225,169)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 204,920	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,432,193	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 386,755	$	26
27	Officer's Accounts Payable	4,225		27
28	Accounts Payable-Patient Deposits	6,500		28
29	Short-Term Notes Payable	374,794		29
30	Accrued Salaries Payable	97,421		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,672		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,437		32
33	Accrued Interest Payable	42		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 925,846	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 925,846	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 506,347	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,432,193	$	48

*(See instructions.)

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 189,393	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 189,393	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	316,954	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 316,954	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 506,347	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,202,374	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,202,374	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	229,282	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 229,282	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	3,157	28
28a	VENDING COMMISSIONS (NET OF COST)	6,726	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,883	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,441,558	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	895,999	31
32	Health Care	2,215,468	32
33	General Administration	904,653	33
	B. Capital Expense		
34	Ownership	895,525	34
	C. Ancillary Expense		
35	Special Cost Centers	106,744	35
36	Provider Participation Fee	106,215	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,124,604	40
41	**Income before Income Taxes (line 30 minus line 40)****	316,954	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 316,954	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** TAX RETURN CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,511	1,625	$ 36,758	$ 22.62	1
2	Assistant Director of Nursing	1,980	2,060	39,663	19.25	2
3	Registered Nurses	5,439	5,522	111,640	20.22	3
4	Licensed Practical Nurses	27,669	28,936	502,928	17.38	4
5	Nurse Aides & Orderlies	100,889	103,997	1,075,051	10.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,842	1,858	19,429	10.46	8
9	Activity Director	1,389	1,659	17,369	10.47	9
10	Activity Assistants	2,481	2,742	18,509	6.75	10
11	Social Service Workers	5,800	6,047	63,149	10.44	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	22,236	10.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,589	6,953	52,494	7.55	15
16	Dishwashers	9,046	9,274	64,030	6.90	16
17	Maintenance Workers	2,283	2,443	46,727	19.13	17
18	Housekeepers	18,033	18,837	138,641	7.36	18
19	Laundry	7,496	7,730	54,290	7.02	19
20	Administrator	2,040	2,080	48,743	23.43	20
21	Assistant Administrator					21
22	Other Administrative	1,069	1,178	16,107	13.67	22
23	Office Manager	2,078	2,230	24,331	10.91	23
24	Clerical	2,070	2,070	20,519	9.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,734	3,926	47,352	12.06	28
29	Resident Services Coordinator	1,916	2,196	39,210	17.86	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,764	1,864	16,330	8.76	31
32	Other Health C: CARE PLAN	1,984	2,080	34,084	16.39	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,054	219,387	$ 2,509,590 *	$ 11.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	183	$ 8,216	1-3	35
36	Medical Director		0	9-3	36
37	Medical Records Consultant	10	360	10-3	37
38	Nurse Consultant	32	1,622	10-3	38
39	Pharmacist Consultant	MONTHLY	1,535	10-3	39
40	Physical Therapy Consultant	80	3,190	10a-3	40
41	Occupational Therapy Consultant	50	2,056	10a-3	41
42	Respiratory Therapy Consultant	12	490	10a-3	42
43	Speech Therapy Consultant	3	120	10a-3	43
44	Activity Consultant	10	238	11-3	44
45	Social Service Consultant	146	5,113	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	526	$ 22,940		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	80	$ 2,866	10-3	50
51	Licensed Practical Nurses	128	3,612	10-3	51
52	Nurse Aides	(10)	(200)	10-3	52
53	TOTAL (lines 50 - 52)	198	$ 6,278		53

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TINA BATTERTON	ADMIN	0	$ 48,743
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 48,743

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 11,975
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 11,975

C. Professional Services

Vendor/Payee	Type	Amount
MICHAEL BEST FRIEDRICH	LEGAL	$ 8,706
WINSTON STRAWN	LEGAL	1,707
TENNEY BENTELY	LEGAL	956
KRUPNICK BOKOR KAGDA	ACCTG SVCS	8,585
RICHARD PEELO & ASSOC	MDCR COST REPORT	3,750
ROBERT MILLER		202
DUANE MORRIS	HR CONSULTING	2,059
PERSONNEL PLANNERS	HR CONSULTING	1,978
CERTIFIED HEALTH	ADMIN CONSULTING	32,410
PAYCHEX	DATA PROCESSING	7,208
ECONOCARE	PURCHASE CONSULT	2,328
CORCORAN	401K PLAN AUDIT	333
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 70,222

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,677
Unemployment Compensation Insurance	21,389
FICA Taxes	190,039
Employee Health Insurance	97,488
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	847
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	2,991
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
RELATED PARTY	27,780
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	10,551
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	8,667
TRUST/FRANCHISE/CONTRIB/ETC	2,431
LICENSES & PERMITS	1,398
DUES & SUBSCRIPTIONS	14,072
RELATED PARTY	254
TRUST/FRANCHISE/CONTRIB/ETC	(2,431)
Less: Public Relations Expense	(0)
Non-allowable advertising	(8,667)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,475

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,931
RELATED PARTY	2,762
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,693

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5								N/A					
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL HEALTHCARE ASSOC $11,652

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,073 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 106,215
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ #REF! Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? 5%

d. Have vehicle usage logs been maintained? NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES

g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: RENAISSANCE CARE CENTER #0040295 **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,216	
	REPAIRS & MAINTENANCE		0	
			0	8,216
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,872	
			0	1,872
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		21,031	
	ELECTRICITY		67,192	
	WATER		21,128	
	CABLE TV - LOBBY		288	
			0	109,639
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,923	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,263	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		895	
	FIRE SERVICE		181	
			0	
			0	
			0	12,262
7	**OTHER**			
	SCAVENGER		4,328	
	SECURITY SERVICE		0	4,328
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	6,278	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	360	
	PHARMACY CONSULTANT	XVIII B 39-2	1,535	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	1,622	
			0	
			0	9,795
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,190	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,056	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	490	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	120	5,856
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	238	
				238
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,113	
			0	5,113
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number RENAISSANCE CARE CENTER **#0040295** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	11,975	11,975
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	7,208	
	ADMINISTRATIVE CONSULTANTS	XIX C	32,410	
	PROFESSIONAL FEES	XIX C	30,604	
			0	70,222
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,667	
	EMPLOYEE WANT ADS	XIX F	10,551	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	14,072	
	LICENSES & PERMITS	XIX F	1,598	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,431	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	37,319
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		9,340	
	EQUIPMENT REPAIR & MAINTENANCE		1,956	
	OUTSIDE CLERICAL SERVICES		141,940	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,305	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		581	
	TELEPHONE		9,744	
			0	167,866

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	190,039	
	UNEMPLOYMENT COMPENSATION	XIX D	21,389	
	WORKERS COMPENSATION INSURANC	XIX D	62,677	
	HOSPITALIZATION INSURANCE	XIX D	97,488	
	EMPLOYEE BENEFITS - OTHER	XIX D	847	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	2,991	
	CHICAGO HEAD TAX	XIX D	0	375,431
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,947	1,947
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	1,931	
			0	
			0	1,931
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,316	10,316
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		92,030	92,030
27	**OTHER**			
	BAD DEBTS	VI 24	5,376	
			0	5,376

GRAND TOTAL COLUMN 3 OTHER 931,732